STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 28, 2012 through April 5, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 150. The survey sample included forty (40) census sample residents and thirty (30) admission sample residents in Stage I. The Stage II sample totaled thirty eight (38) residents.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Ellen Rodgers TITLE: NHA (X6) DATE: 5/1/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to identify a situation of potential resident to resident abuse, failed to report this allegation to the State agency, failed to complete a thorough investigation and consequently failed to submit a 5 day follow up for 1 (R284) out of 38 Stage II sampled residents. Findings include: R284 was admitted to the facility on 4/19/11 with diagnoses of Alzheimer's Disease/dementia, congestive heart failure, and chronic obstructive pulmonary disease. Review of the Significant Change Minimum Data Set (MDS), dated 5/15/11, coded R284 as having short and long term memory loss and being severely impaired in cognitive skills for daily decision making. Additionally, R284 was coded as requiring extensive assistance of two persons for bed mobility and transfer.	F 225	**F225 – Investigate/Report Allegations/Individuals.** It is the practice of the facility that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. It is the practice of the facility to maintain evidence that all alleged violations are thoroughly investigated and the practice of the facility to prevent further potential abuse while the investigations are in process.	5/16/12

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F 225	Continued From page 2 Review of the Nurses' Notes for R284, dated 6/23/11 at 6:00 AM, revealed, "Pt A/O (patient alert and oriented) no s/s (signs/symptoms) of bruising noted as roommate (Resident who chose to be antonymous) states that the third roommate (R195) was hitting him (R284) while in bed, because he (R195) c/o (was complaining) he (R284) was making noise.. patient (R284) removed out of the room will continue to monitor." The resident who chose to be anonymous was coded on an admission MDS, dated 5/10/11, as being alert and oriented with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 3/29/12 this anonymous resident in an interview, stated that he observed that R195 was at R284's bed side and heard R284 state that R195 was hurting his eye. On 4/5/12, in an interview with E16 (Nurse), she stated that the resident who reported the event told her that R195 was out of bed and thought that R195 was hitting R284. E16 stated that she entered the room to give medications and the three residents were in bed. E16 stated that was when the anonymous resident told her of the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that she did not do an incident report because when she went into the room, there was no evidence that R195 was out of bed and she did not feel it was necessary. Also, E16 stated that she passed on the information about the "incident" in report to the next shift but did not remember to whom. On 4/4/12, in an interview with E6 (RN/Director of	F 225	It is the practice of the facility to report the results of all investigations to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident and if the alleged violation is verified appropriate corrective action is taken. Resident #284 no longer resides at the facility. Nurses' notes of current residents will be audited for evidence of documentation of alleged resident to resident abuse back through April 5, 2012. The Staff Development Coordinator or designee will in-service employees on identifying and reporting alleged resident to resident abuse.	5/16/12

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F 225	Continued From page 3 Care Delivery), he stated that he was not aware of any resident to resident issues between R284 and R195. Also, E6 stated that he receives all of the incident reports so that he would be aware if there were any issues of resident to resident problems/abuse. The facility failed to identify an alleged resident to resident abuse, failed to report, failed to complete a thorough investigation and failed to complete a 5 day follow up. On 4/5/12, in an interview with E2 (Director of Nursing/DON), she confirmed that E16 should have done an incident report and that it should have been investigated.	F 225	The Staff Development Coordinator or designee will in-service licensed nurses on reporting and completing a thorough investigation and on the timely submission to the Division of Long Term Care Residents Protection. The Administrative Director of Nursing has in-serviced employee E-16 on the proper guidelines for reporting alleged resident to resident abuse.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews during the environmental tour on 4/5/12, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and orderly interior. Findings include: 1. Observation of R271, R226 and R22's wheelchairs revealed that there was encrusted dirt on the frames of these wheelchairs. On 4/5/12, in an interview with E1 (Administrator), E10 (Maintenance Director) and E11 (Housekeeping Director), they confirmed the findings.	F 253	The Administrative Director of Nursing or designee will complete random weekly audits for three months of nurse's notes in daily morning meeting. The Administrative Director of Nursing or designee will complete random weekly audits for three months to evaluate the timely submission of incidents. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	5/14/12

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F 253	Continued From page 4 2. Observation of a Stand-Up lift in the central shower room on the Arcadia unit revealed, that there was food debris and encrusted dirt on the bottom of the Stand-Up lift. On 4/5/12, in an interview with E1, E10 and E11, they confirmed the findings.	F 253	**F253 – Housekeeping and Maintenance Services** It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. R271, R226 and R22 wheelchairs have been cleaned. The stand-up lift on the Arcadia Unit has been cleaned. The Maintenance and Housekeeping Directors have completed environmental rounds to evaluate whether the facility is maintaining an orderly and sanitary interior. The Staff Development Coordinator or designee will in-service staff on identifying and communicating environmental concerns. The Maintenance Director and Housekeeping Director or designee will perform random weekly audits for three months. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.	5/16/12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain an environment free of accident hazards when the facility failed to maintain the ancillary, oxygen tank storage, utility and mechanical rooms locked. Additionally, the facility incorrectly charged the electric wheelchairs in the hallways. Additionally the facility stored equipment on both sides of the hallways which could potentially impede resident travel in the hallways, posing a potential accident hazard. Findings include: 1.Multiple observations of unlocked doors were made during the survey as follows: A.- On 3/28/12 at 8:55 AM and 9 AM, two different surveyors observed the door to the	F 323		

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F 323	Continued From page 5 Oxygen tank storage room on the Linden Hall, unlocked and accessible to residents and visitors which posed a potential accident hazard. On 3/28/12, this finding was confirmed by E14 (Nurse), who also was able to open the door without using the combination. She stated that whoever was last in there, did not ensure that the door was pulled all the way shut. Consequently, the door did not latch. B.- On 3/28/12 at 9:05 AM, the second floor housekeeping room was observed unlocked. This room contained multiple medical supplies including disposable razors that were accessible to residents or visitors which posed a potential accident hazard. During an interview on 3/28/12, E10 (Maintenance Director) confirmed the findings and stated that he would adjust the hinge. C. - On 4/2/12 at 11:20 AM, the door to the mechanical room was observed unlocked.This room contained electrical panels. It was brought to the attention of 2 staff, E7 (nurse/unit director) and E23 (nurse), who stated that they would call the maintenance staff, then both left the area and the door unlocked and accessible to residents and visitors which posed a potential accident hazard. During an interview on 4/2/12, E13 (Director of Physical Therapy) confirmed the finding and stated that the door should be locked. D. - On 4/4/12 at 1:05 PM, the "clean utility room" which stored oxygen tanks was observed	F 323	**F323** – It the practice of this facility to ensure that the resident's environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. The facility immediately placed temporary pad locks on the ancillary, oxygen storage and utility rooms. The employee was in-serviced on making sure that the mechanical door room is locked at all times. Electric wheelchairs are no longer being charged in hallways. Equipment has been moved to one side of the hallway on each unit. An audit of the electric wheelchairs was completed to evaluate that charging was performed in the appropriate area.	

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F 323	Continued From page 6 unlocked and accessible to residents. E15 (nurse) was asked to try to open the door. E15 was able to open and shut the door twice without the door locking. Finally, on the third try, the door locked. Again, this posed a potential accident hazard. This was confirmed with E15 (nurse). 2. During the initial tour, on 3/28/12, there were multiple observations by two surveyors on the second floor of equipment being stored on both sides of the hallway, posing a potential impediment for residents to be able to travel down the hallways on one side as follows: A. On 3/28/12 at 8:15 AM, Heritage II Hall equipment was stored on both sides of the hall: observations included: on one side - a linen cart was stored between rooms 230-231; on the other side of the hall - one large wheelchair outside Room 228 and a large wheelchair with oxygen parked past the exit door by the window, outside of Room 227. B. On 3/28/12 at 8:20 AM, Kennett Hall was observed with equipment stored on both sides of the hall - this included: an electric wheelchair charging in the hall in a red emergency outlet outside of Room 218 and a meal cart; on the other side of this hall was observed a geri chair between Rooms 213-214, a linen cart outside Room 215, a hoyer lift outside Room 212, and a wheelchair and chair scale parked in front of a storage door to the right of the central bath. During an interview on 3/28/12 at 9:00 AM, E25 (CNA) stated that the electric wheelchair	F 323	An audit was completed to evaluate that facility equipment was on only one side of the hallway. The Housekeeping Director or designee will complete random weekly audits for three months of the ancillary, oxygen storage, utility and mechanical rooms to ensure that electric wheelchairs are charged in the appropriate area and equipment is stored on only one side of the hallway. The Staff Development Coordinator or designee will in-service staff on locking ancillary, oxygen storage, utility and mechanical rooms at all times, charging electric wheelchairs in appropriate locations, and storing all equipment on only one side of the hallway. Results of these audits will be forwarded to Quality Assessment and Assurance Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.	

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F 323	Continued From page 7 belonged to a resident in Room 215 on the other side of the hall. She confirmed the finding and stated that electric wheelchairs were supposed to be charged in the beauty shop. C. On 3/28/12 at 8:25 AM, Yorklyn Hall was observed with equipment on both sides of the hall: observations included a metal dolly (equipment used to move items) parked in the hall across the housekeeping door, a specialized chair with wheels between Rooms 209-210, a linen cart and stand-up scale parked between Rooms 207-208. On the other side of the hall between Room 205 and the Exit door was observed a geri chair, wheelchair and a caution wet floor sign lying flat on the floor in front of the wheels just before the exit door. Additionally, there was a meal cart parked between Rooms 202-203. Again, this posed a potential impediment for residents to be able to travel down the hallways on one side. D. On 3/29/12 at 7:35 AM, the same electric wheelchair was observed being charged in the Kennett hall using the red emergency socket outside of Room 218. The wheelchair was incorrectly charged in the hallway which posed an accident hazard and should have been charged in a safe area approved by the fire marshall.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	**F371 –Food Procure, Store/Prepare/Serve-Sanitary** It is the practice of the facility to store, prepare, distribute, and serve food under sanitary conditions. The Administrative Director of Nursing in-serviced E21 on proper hand hygiene when distributing and serving food.	

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F 371	Continued From page 8 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on an observation made during the dining observation of the lunch meal and staff interview, it was determined that the facility failed to serve and distribute food under sanitary conditions in the Stratford Dining Room. Findings include: On 3/28/12, during the luncheon observation in the Stratford Dining Room, E21 (CNA) was observed removing a tray from a dining table. E21 went to the trash can to discard used paper items, lifted the trash can lid with her bare hands and then went out to the cart to get another resident's tray. The surveyor asked to speak with E21. E21 confirmed that she did not wash her hands or use hand sanitizer after lifting the trash can lid with her bare hands, confirming the observation. Also, E21 stated and showed the surveyor that she had hand sanitizer in one of her pockets.	F 371	The Staff Development Coordinator or designee will in-service Nursing staff on proper hand hygiene when distributing and serving food. The ADNS or designee will complete random weekly audits for three months to evaluate proper hand hygiene when distributing and serving food. Results of these audits will be forwarded to Quality Assessment and Assurance for review and action as appropriate. The Quality Assessment and Assurance Committee will determine further audits and/or action plans.	5/16/12
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 372	**F372 – Dispose Garbage & Refuse Properly** It is the practice of the facility to dispose of garbage and refuse properly and to ensure compactor is covered to prevent pest harborage. The facility refuse compactor was repaired to prevent pest harborage.	

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F 372	Continued From page 9 Based on observations on 3/28/12, it was determined that the facility failed to maintain the garbage dumpster outside the facility in good condition. Findings include: An observation on 3/28/12 revealed, that the outside dumpster lid had a two inch gap. This provides harborage for unwanted pests. On 3/28/12 in an interview with E10 (Maintenance Director), he confirmed the above finding.	F 372	The Maintenance Director or designee will monitor/audit the garbage and refuse compactors at the facility for compliance. The Maintenance Director or designee will complete weekly random audits for three months of the facility's refuse compactor to evaluate proper disposal methods and whether coverage provides prevention of pest harborage. Results of these audits will be forwarded to the Quality Assessment & Assurance Committee for review and action as appropriate. The Quality Assessment & Assurance Committee will determine the need for further audits and/or action plans.	5/16/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	**F431 – Drug Records, Label/Store Drugs & Biologicals** It is the practice of the facility to label and store drugs and biologicals according to currently accepted professional principles.	5/16/12

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F 431	Continued From page 10 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to ensure that the drugs and biologicals that were stored in the medication refrigerators were not expired. Findings include: 1. An observation on 4/4/2012 of the medication refrigerator on the Arcadia Unit revealed that there was one open vial of Aplisol (PPD/Tuberculin Skin Test) which did not have a date as to when it had been opened. Package insert for this medication states that once open, this medication must be discarded within 30 days. An interview on 4/4/2012 with E23 (nurse) confirmed the above findings. 2. An observation on 4/4/2012 of the medication refrigerator on the second floor revealed that there was one open vial of Aplisol (PPD/Tuberculin Skin Test) dated 2/5/2012 and two open vials of Aplisol that did not have a date on them for when they had been opened. Package insert for this medication states that once open, this medication must be discarded within 30 days.	F 431	Facility immediately disposed of the PPD/Tuberculin skin test solution on the Second Floor and Arcadia/Heritage Unit. An audit of all medication storage areas was completed to evaluate the proper labeling and storage of PPD/Tuberculin skin test solution. The Staff Development Coordinator or designee will in-service nursing staff on proper storage and labeling of PPD/Tuberculin test solution. The Director of Care Delivery or designee will complete random weekly audits for three months to evaluate whether PPD/Tuberculin test solutions are labeled, stored properly and disposed of by the expiration date. Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans.	5/16/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 11 An interview on 4/4/2012 with E24 (nurse) confirmed above findings.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	**F441 – Infection Control, Prevent Spread, Linens** It is the practice of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Facility contracted employees have current PPD/Tuberculin skin test. E22 was in-serviced on proper cleaning of an accu-check machine. Housekeeping and Food Service Directors completed audits of employee files to evaluate that employees have current PPD/Tuberculin skin testing in place.	5/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 441	Continued From page 12 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined that the facility failed to maintain infection control practices designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of disease and infection. Findings include: 1. Review of facility employee records revealed that three staff out of twelve reviewed did not receive their Tuberculin Skin Test (PPD) when they were first hired. These employees were: E17 (Dietary Aide) with a date of hire of 9/27/2011, E18 (Dietary Aide) with a date of hire of 7/24/2011 and E19 (Housekeeping Staff) with a date of hire of 1/20/2012. On 4/5/2012, these findings were confirmed with E2 (Director of Nursing). 2. On 4/3/12 at 11:57 AM, an observation was made of E22 (Nurse) coming out of R353's room with an Accu Check machine that tests residents' diabetic status/blood sugar. E22 stated that she had just completed the Accu Check on R353. E22 then proceeded to clean the Accu Check machine with an alcohol wipe. She was about to put the machine back in the medication cart drawer when the surveyor asked her what she used to clean the Accu Check machine? E22	F 441	The Staff Development Coordinator or designee will in-service the Housekeeping and Food Service Directors that new employees are required to have a two-step PPD/Tuberculin skin test. The Housekeeping and Food Service Directors will complete random monthly audits for 6 months to evaluate employee files for evidence of two-step PPD/Tuberculin skin test upon hire. The results of these audits will be forwarded to the Quality Assessment & Assurance Committee for review and action as appropriate. The Quality Assessment & Assurance Committee will determine the need for further audits and/or action plans.	5/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 13 responded that it was an alcohol wipe. After being questioned about the alcohol wipe she used, E22 then proceeded to appropriately disinfect the Accu Check machine with a bleach wipe which she had on the medication cart. E22 stated that she had ruined a couple of tops with the bleach wipes in the past. Additionally, E22 stated that she cleans the Accu Check machine with each resident use and usually uses the bleach wipes. The facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by improperly cleaning the Accu Check machine with an alcohol wipe. On 4/3/12, E22 confirmed the findings.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

ME OF FACILITY: Manor Care Pike Creek

DATE SURVEY COMPLETED: April 5, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal report. An unannounced annual and complaint survey was conducted at this facility from March 28, 2012 through April 5, 2012. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 159. The survey sample included forty (40) census sample residents and thirty (30) admission sample residents in Stage I. The Stage II sample totaled thirty eight (38) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of**	State Cross refer to CMS 2567-L survey date completed 4/5/12, F225, F253, F323, F371, F372, F431 and F441. 5/16/12

Provider's Signature Mary Callery Title NHA Date 5/1/12

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STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Pike Creek

DATE SURVEY COMPLETED: April 5, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 4/5/12, F225, F253, F323, F371, F372, F431, F441	5/16/12